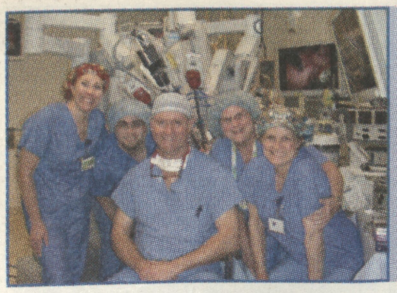
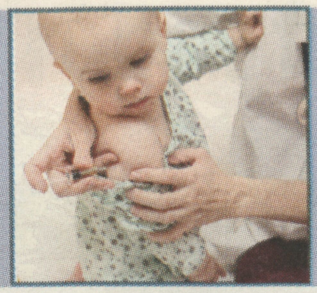


da Vinci robot used for throat surgery

— Page 3



Pharmaceutical Focus

— Page 4

The Portland Physician SCRIBE

Vol. 28 No. 9 Published by the Medical Society of Metropolitan Portland on the 1st & 3rd Fridays May 7, 2010

MSMP's charitable wing has supported good works for 18 years

By Cliff Collins

Medical students sponsoring a health-screening fair for the uninsured, and a workshop to encourage immunization education and training were among grant recipients in April from the Metropolitan Medical Foundation of Oregon.

The foundation, which goes by the acronym MMFO, is the community-outreach affiliate of the Medical Society of Metropolitan Portland. Funded entirely from donations by MSMP members, MMFO's mission is to support activities that improve health education and the delivery of health care to the community.

The foundation's history dates to 1992, when John W. Kendall Jr., MD, who was just completing his service as MSMP president, and Cathy Krieger, who had headed MSMP's Auxiliary, saw a need to create an organization that could raise and distribute direct funding to worthy efforts, said Krieger, who along with Dr. Kendall and insurance executive James Fenimore founded MMFO. The Medical Society, its auxiliary and Fenimore contributed $5,000 apiece to launch the foundation.

In the early years, MMFO awarded a number of grants aimed at child immunization. Since then, MMFO has become quite diversified in its grant making, seeking to meet community needs that are consistent with its mission. In 2002, MMFO established a mini-grant program, which awards grants up to $500 to groups developing small projects.

The foundation's current total assets are $20,000. "We generally collect $2,000 to $5,000 a year," said Krieger, who serves as presi-

Please see CHARITABLE WING, page 4

Jinnell Lewis, a third-year student at OHSU, volunteers at the Cover The Uninsured Week Health Screening Fair put on by OHSU students at O'Bryant Square in downtown Portland April 18. The event was held in part thanks to a grant from the Metropolitan Medical Foundation of Oregon, the community outreach affiliate of the Medical Society of Metropolitan Portland.

State senator sees a viable public option for all Oregonians

Alan Bates, a physician, is looking into the idea of a federal waiver for Oregon

By Jon Bell

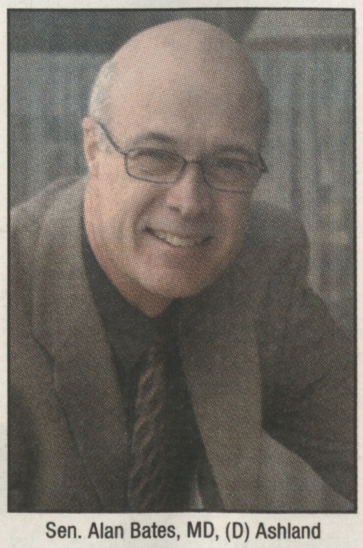
In 1993, Oregon became one of the first states in the nation to win federal approval of a Medicaid waiver, a key step in setting up the Oregon Health Plan.

In 2004, the state became one of the first to implement a provider tax to help provide insurance for low-income citizens.

And if Sen. Alan Bates, D-Ashland, has his way, Oregon may become the first state to offer a public option to any and all of its citizens.

"We were the first state to get a Medicaid waiver," said Bates, himself a primary care doctor in Medford. "We broke that one open. We might break this one open too."

Bates' idea for a public option for Oregonians came to the surface recently with Congress's passage of the federal health care reform package this spring. Despite initial talk of such an option, the final legislation contained nothing of the sort.



Sen. Alan Bates, MD, (D) Ashland

What it did include, however, was an amendment from Oregon Sen. Ron Wyden that allows states to exclude themselves from the new federal plan and essentially set up their own corresponding systems. To opt out of the federal plan, a state would have to submit a waiver to the federal government explaining why and also demonstrating the benefits and services of the state's plan.

What Bates potentially sees — "We're just in the very early discussions," he noted — is Oregon opting out of the federal plan and creating a public option by expanding OHP, the state's Medicaid program. Citizens would have the option of buying into OHP and, where applicable, using the same subsidies that will be available to people buying insurance through the federal plan's new insurance exchange.

Having fewer uninsured people would ultimately help curb the cost shift that plagues the health care system. Currently, insurance companies charge business and individual customers higher and higher premiums to help cover the costs incurred by the uninsured.

Bates said the public option in Oregon would be run through the existing managed care plans that provide coverage for OHP.

"That's how we can lower costs and control costs," he said.

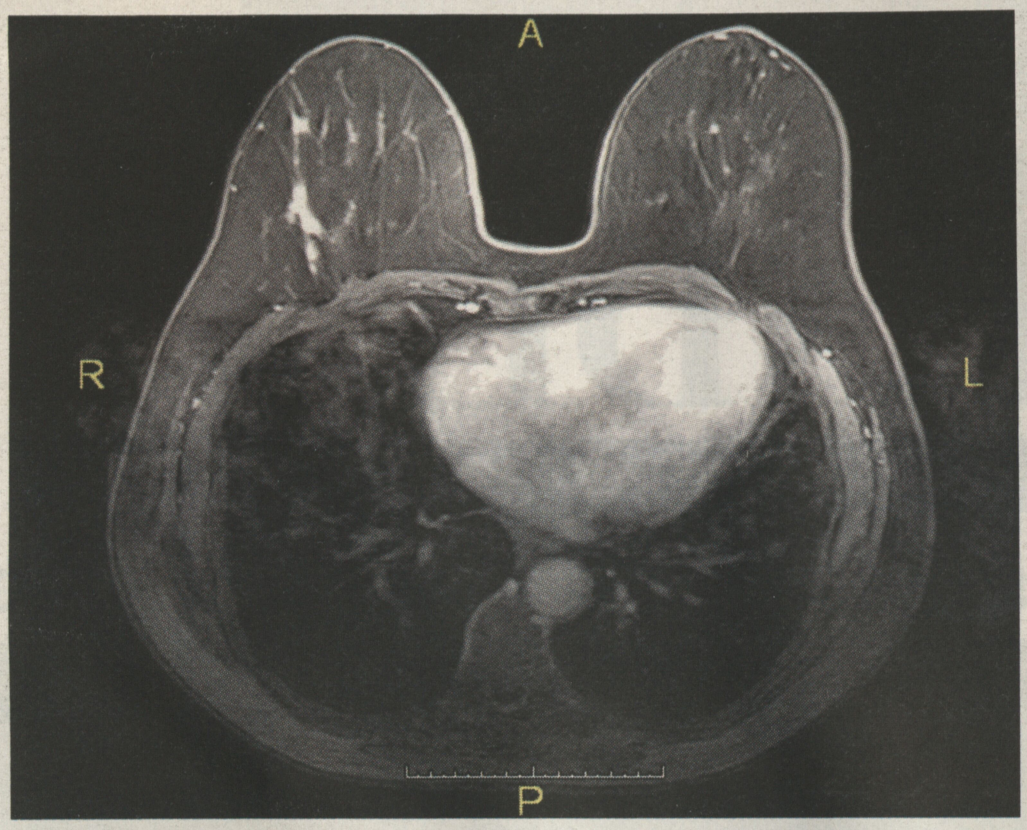
People who chose to buy into the public option would need to realize that coverage through it would come with some restrictions. Patients would likely be required to see a primary care doctor before going to a specialist, for example, and their prescription drug coverage might be based on a less extensive formulary than one that would accompany a more expensive commercial plan.

In exchange for such restrictions, however, premiums would cost less.

"If people wanted a Cadillac plan, they'd have to go somewhere else," Bates said. "This would be very basic coverage, and it would be a public option, not a public mandate."

Under Bates' idea, the public option would not require additional dollars from the state. It would also be operated on a level playing field with commercial insurance providers so it wouldn't have a leg up. Oregonians already

Please see SENATOR BATES, page 5



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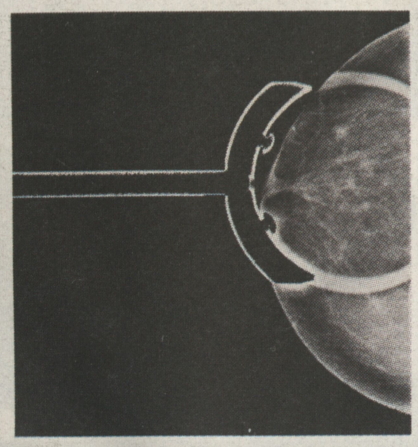
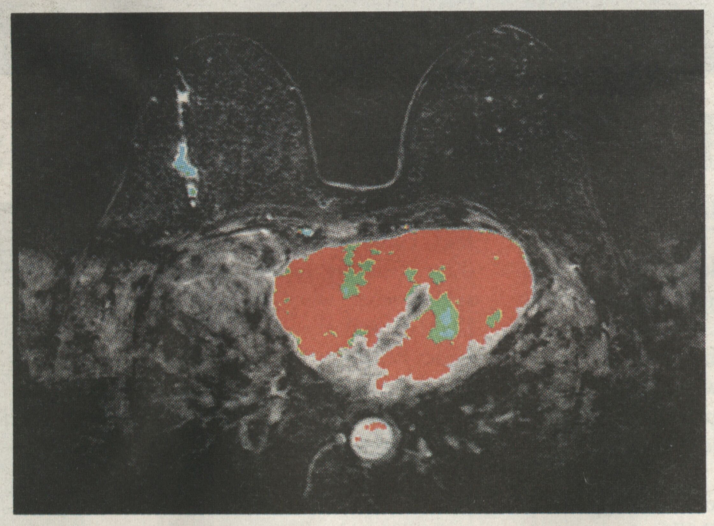


Mammogram



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Breast MRI identified two lesions suspicious for neoplasm in the right breast, one of which corresponded to the mammographic nodule and a second larger lesion that was not seen on either mammography or ultrasound. Following consultation with the referring physician and patient, core samples were obtained of both lesions with MRI-guided biopsy. Findings indicate the presence of invasive ductal carcinoma and comedo ductal carcinoma in the second larger lesion situated near the posterior chestwall and invasive ductal carcinoma in the smaller lesion more anterior towards the nipple.

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Local physician using robot for throat cancers

By Cliff Collins

Robotic surgery continues its rapid growth into new applications after a Portland surgeon recently performed the first oral surgeries on the West Coast using the da Vinci Surgical System.

On March 31, otololaryngologist Eric J. Dierks, MD, DMD, did two transoral robotic surgeries at Legacy Emanuel Medical Center to treat oral cancers.

Until now, surgical use of the da Vinci has been dominated by urological operations, and also has seen increased use for gynecological procedures. Legacy Good Samaritan Medical Center has begun employing the device for heart procedures. But use of the da Vinci for the head and neck received Food and Drug Administration approval only at the beginning of this year.

Dr. Dierks, who is board certified in otolaryngology, head and neck surgery, as well as oral and maxillofacial surgery, became interested in robotic surgery more than a year ago. He heard scientific presentations on it, and took "a familiarization course along with gynecologists and urologists," he explained.

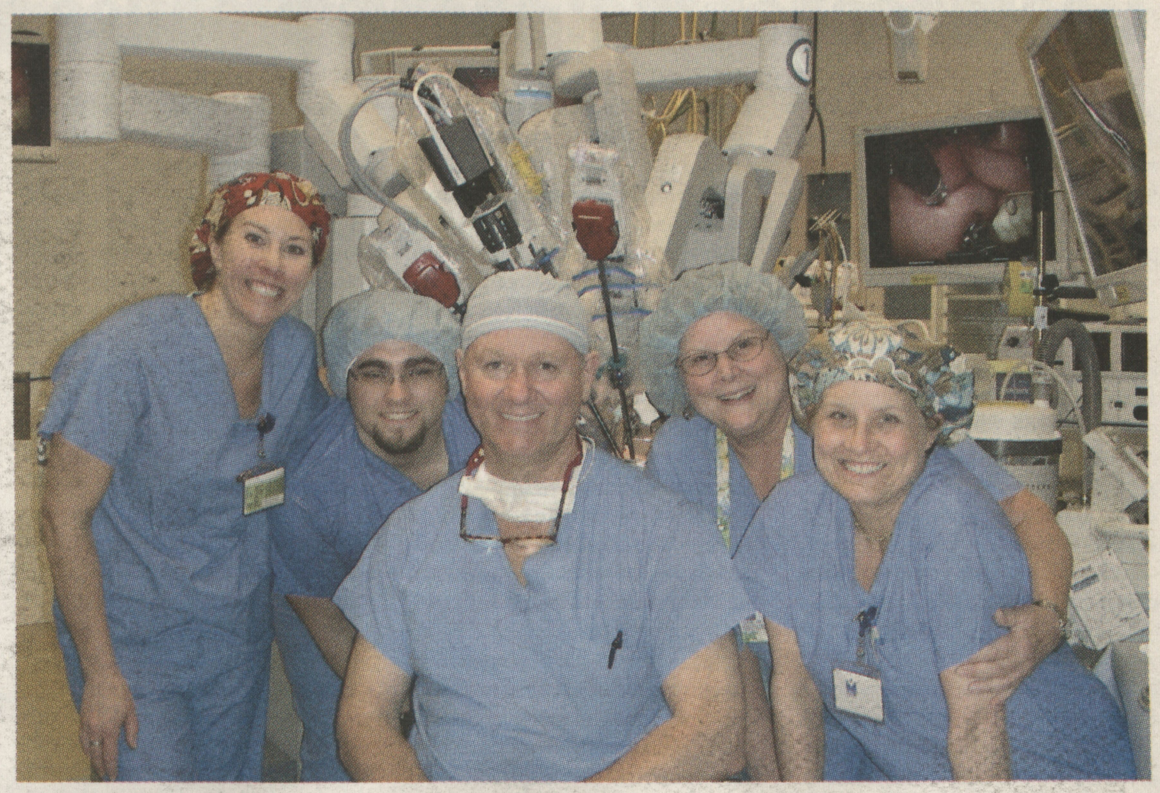
After training in the facilities of Intuitive Medical Inc. in Sunnyvale, Calif. — the manufacturer of da Vinci robots — and at the University of Pennsylvania School of Medicine — which pioneered da Vinci for transoral robotic surgeries — Dr. Dierks achieved certification from Intuitive.

At Penn, he was one of only three ENTs there at the time, the other two being from academic centers, and after gaining certification, he was in position to do the first such surgeries on the West Coast.

According to Oral Cancer News, Penn founded the first transoral robotic surgery program there in 2004. Surgeons developed the approach for both malignant and benign tumors of the mouth, voice box, tonsil, tongue and other parts of the throat. Since 2005, approximately 350 patients have participated in the first prospective clinical trials.

The da Vinci, when used "specifically for surgeries inside the throat above the vocal cords, offers tremendous advantages," Dr. Dierks said. Head and neck tumor treatments often involve a combination of surgery, radiation therapy and chemotherapy, and the operations are "fairly radical surgeries" of eight to nine hours, often requiring splitting the jaw and tongue, followed by extensive, intricate reconstruction, he said.

By contrast, robotic surgery doesn't require grafts and is "much less invasive," he said, resulting in shorter hospital stays, less risk of bleeding, scarring and infection, and quicker recovery. The minimally invasive transoral approach has been shown to improve long-term swallowing function while speeding up recovery time.



Dr. Eric Dierks and his surgical team recently performed the first transoral robotic surgery using the da Vinci robotic system at Legacy Emanuel Medical Center. From left are Jen Cameron, Josh Dodd, Dr. Eric Dierks, Lois McIntosh and Suzie Ellis.

"I am thoroughly impressed," Dr. Dierks said shortly after completing the first two operations. "It's precise, fun to do, and easy; it comes naturally to a surgeon." The new, recently installed da Vinci at Emanuel will be shared by different types of surgeons, but still will be used predominantly by urologists and gynecologists, he said.

Although some surgeons have said they miss the tactile feedback when using the da Vinci, Dr. Dierks said he found the robot "surprisingly easy to learn," with the loss of tactile feedback quickly mitigated by the "visualization and visual feedback" afforded by the machine. "It's very easy to blow up (an image) or back off for a wider field view."

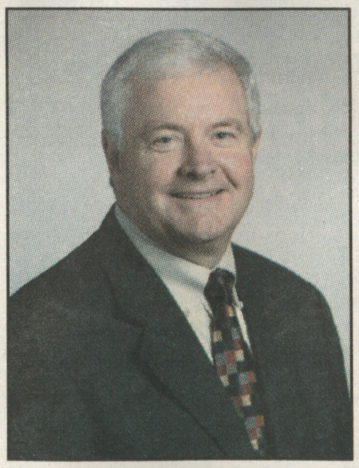
Indications for use "are somewhat fluid right now," Dr. Dierks said. The area of general indication is for cancer of the tonsil, the back of the tongue, and the area of the larynx above the vocal cords, he said. "That's where we are now. We see this in the future for (use with the) posterior oral cavity, palate and posterior parts of the mouth."

Following standard surgery, the current paradigm is chemotherapy and radiation, but the problem with those are that side effects are permanent, he said. Also, radiation generally can be employed only once in a specific body region. Robotic surgery may "save the patient a great deal of morbidity," and allow lower dosages of radiation after surgery, Dr. Dierks said.

"Based on our data and patient outcomes ... we are changing the way oropharyngeal cancer and tumors will be treated now and in years to come," Gregory Weinstein, MD, professor and vice chairman of Penn's department of ENT, head and neck surgery told ScienceDaily. He added that his colleagues are investigating robotic treatments for other conditions such as sleep apnea, as well as collaborating with neurosurgeons.

Providence Oregon names new Chief Executive

Providence Health & Services has announced that Greg Van Pelt will become the new chief executive for Providence's Oregon Region, effective July 1, 2010. Van Pelt has served Providence for 34 years, most recently as executive vice president for the five-state health system. Van Pelt will replace Russ Danielson, who earlier this year announced his retirement.



Greg Van Pelt
Chief Executive
Providence Oregon

In making the announcement, John Koster, M.D., president of Providence Health & Services, noted Van Pelt's extensive experience with integrated health care services. Van Pelt has served in a variety of leadership roles at Providence, including as chief executive for Providence St. Vincent Medical Center and for Providence Health Plans. Van Pelt will continue to serve in a leadership role for the five-state system in addition to his Oregon responsibilities.

"I have tremendous respect for the leadership provided by Russ Danielson and the entire Oregon team," said Van Pelt. "These are the people who will continue to guide us as we work to create the delivery system of the future.

Van Pelt received his bachelor's degree in economics from Villanova University and his master's degree in health care administration from St. Louis University. He is a fellow in the American College of Health Care Executives and has served on the boards of directors for Catholic Healthcare Association and for Mercy Health System in St. Louis.

Doernbecher trial shows promise for rare-disease therapy

By Cliff Collins

A clinical trial to test the safety and preliminary efficacy of purified human neural stem cells in children with a rare neurodegenerative disease has shown favorable safety and long-term survival.

The Phase I trial of HuCNS-SC, conducted at OHSU Doernbecher Children's Hospital, included six children with advanced stages of infantile and late-infantile neuronal ceroid lipofuscinosis, or NCL, often referred to as Batten disease. The study participants were transplanted with HuCNS-SC cells and followed for 12 months.

Overall, the Phase I data demonstrated that high doses of HuCNS-SC cells transplanted directly into multiple sites within the brain, followed by 12 months of immunosuppression, were well-tolerated by all six participants. The participants' medical, neurological and neuropsychological conditions following transplantation appeared consistent with the normal course of the disease.

The Doernbecher center was the first in the world to implant neural human stem cells directly into the brains of children with NCL.

"The OHSU research team worked very hard to carry out this highly complex research and is heartened to see that this approach appears to be safe," said Robert D. Steiner, MD, co-principal investigator and professor of pediatrics and molecular and medical genetics, and vice chairman for Doernbecher pediatric research. "We are delighted that this first trial of human neural stem cells was successful and offers hope for effective treatment of NCL and other neurodegenerative disorders."

HuCNS-SC is a proprietary product produced by StemCells Inc., a clinical-stage biotechnology company focused on the research, development and commercialization of products derived from stem cell technologies, especially for developing cell-based therapeutics to treat diseases of the central nervous system and liver.

HuCNS-SC is a purified composition of normal human neural stem cells expanded and stored as banks of cells. The company's preclinical research showed that HuCNS-SC cells can be directly transplanted; they engraft, migrate and differentiate into neurons and glial cells; and they survive for as long as one year with no sign of tumor formation or adverse effects. These findings show that HuCNS-SC cells, when transplanted, act like normal stem cells, suggesting the possibility of a continual replenishment of normal human neural cells.

"It was a privilege for our team to care for these precious children," said Nathan R. Selden, MD, PhD, co-principal investigator and Campagna associate professor and head of the division of pediatric neurological surgery at Doernbecher. "We are indebted to our patients and their families for taking us into this new era of therapy for the central nervous system. We hold out great hope in the future for them and for others around the world with similar diseases that today have no cure."

The researchers presented the study results last year at the 12th International Congress on NCL, held in Hamburg, Germany.

StemCells Inc. submitted the final study report to the Food and Drug Administration and plans to explore the prospects for future clinical development of HuCNS-SC as a potential treatment for infantile and late-infantile NCL.

The company now is conducting a clinical trial using this product to treat Pelizaeus-Merzbacher Disease, a rare and fatal brain disorder that mainly affects young children.

For more information: www.stemcellsinc.com/news/100210.html

CHARITABLE WING

Continued from page 1

dent of MMFO. Funding comes from the opportunity to contribute on annual dues forms, and occasionally doctors send in checks independently, she said.

In 2008, a donor offered a one-to-one match. "That year we collected about $5,700, which the donor then matched with $5,700." MSMP staff donates administrative support to MMFO. "We have very little overhead" expense, mainly printing letterhead and paying corporation dues to remain a charitable organization, she said.

Limited funds require that MMFO be selective in making grant awards. The mini-grant program is designed to support small projects, not to contribute small amounts for much larger budgets. Mini-grants usually are not awarded to any organization in consecutive years.

Examples of past grant awards the foundation has made include:

- A family services program received $395 for medical resource books.
- A medical student received $500 for an evaluation of skateboard safety in Tualatin.
- A nursing school received $500 for a simulation for health careers education.
- Three community organizations received $2,000 each for childhood obesity intervention initiatives.
- A public high school received $100 for smoking cessation kits.

Board members of the foundation select recipients to be awarded money, usually once each quarter. MMFO has kept a low profile while supporting worthy causes, and has retained the loyal participation of founders Krieger and Dr. Kendall, who still serve, along with MSMP Executive Director Robert Delf and another MSMP past president, George H. Caspar, MD, who joined the MMFO board in 2002.

In 2005, the board added a medical student representative, which rotates annually, and each year the Medical Society's president-elect serves on the foundation board.

Outgoing board members include Evan A. Los, a fourth-year medical student, and Glenn S. Rodriquez, MD, who was installed as MSMP president on April 6.

Grants MMFO awarded for the first quarter of 2010 were to:

- OHSU Medical Student Health Policy Group, $500, for "Cover the Uninsured Week," to sponsor a health screening fair.
- Center for Environmental Equity, for "Clean-to-Green Project" activities, $400, to sponsor a public education outreach project describing and demonstrating proper disposal of unused and leftover prescription drugs. Potential misuse by youth with access to prescription drugs stored at home receives the most attention. Other targets include those households impaired or limited by age, income, mobility, acuity and English proficiency.
- Oregon Partnership to Immunize Children, $1,400, for Roundtable Workshop in Washington County. This event provides science-based immunization education and training. It also promotes the Vaccines for Children Program and the Oregon Immunization ALERT Registry. Roundtable attendees typically include health care professionals, professors and students, county immunization coordinators, state agency and tribal immunization personnel, health educators and coalition leaders.

Krieger said MMFO welcomes ideas for projects to be funded; for some quarters, the foundation receives no grant applications. For more information about past project recipients and how to apply for grants or make donations: www.mmfo.org

Krieger said physicians who are interested in joining the board are welcome, and can contact her at: rubyclk@aol.com or info@mmfo.org. Potential grant applicants with questions about the process can write to her at: rubyclk@aol.com.

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New study tabs best treatment for childhood epilepsy

By Cliff Collins

Three years ago, Julia, a Vancouver, Wash., elementary school student, began stopping abruptly while reading aloud. She would pause for 10 or 15 seconds, then resume where she left off, not aware that anything had occurred.

Her mother assumed that Julia, now 8, was simply taking breaks to look at the pictures. The behavior went on for two or three weeks.

Then, on a family vacation, Julia suddenly ceased pitching a baseball and began slowly turning in a circle. She was unaware of what was happening and afterward had no recollection of what had occurred. After this episode, her parents took her to the doctor.

Their primary care physician, after running tests to rule out a brain tumor, diagnosed Julia with childhood absence epilepsy, and recommended that she enroll in a new drug trial at OHSU Doernbecher Children's Hospital. Although her parents were leery of giving their daughter medication, Colin M. Roberts, MD, assistant professor of pediatrics and neurology and director of Doernbecher's pediatric epilepsy program, explained to Julia's parents that, without treatment, her seizures would have a serious impact on her learning and development.

After Julia started medication, her seizures stopped. She has been seizure-free for two and a half years, and quit taking the medication several months after she became seizure-free, because it increased her body-mass index.

Now she is a participant in a newly extended follow-up trial at Doernbecher, which was part of the largest-ever National Institutes of Health-funded pediatric epilepsy clinical trial. That trial examined which of three standard treatments for Julia's illness is most effective.

The girl represented one of three study groups: participants who took medication, became seizure-free and stopped taking the medication. The two other groups respectively comprise children who are taking medication but still are having seizures, and children taking medication who are not experiencing seizures.

The study, called the NIH Childhood Absence Epilepsy Study Group, compared three medications typically used to treat childhood absence epilepsy. Prior to this study, no definitive evidence existed about which drug worked best.

"Much of our scientific understanding of childhood epilepsy care today comes from historical experience or studies involving adult patients with related, but not identical, conditions," explained Dr. Roberts, Doernbecher's principal investigator for the study, which was published in March in The New England Journal of Medicine. The hospital was one of 32 comprehensive pediatric epilepsy centers nationwide selected to participate in the landmark clinical trial.

"This study is an important milestone in our understanding of childhood absence epilepsy," he said. "Never before have we been able to document in such a comprehensive, scientific fashion the best options to treat children with this condition."

The study group enrolled 453 children newly diagnosed with childhood absence epilepsy from July 2004 to October 2007. Study participants were randomly assigned to ethosuximide, valproic acid or lamotrigine. Drug doses were incrementally increased until the child was seizure-free. After 16 weeks of therapy, the researchers found that ethosuximide, one of the oldest available anti-seizure medications, is the most effective treatment for childhood absence epilepsy. Ethosuximide and valproic acid were significantly more effective than lamotrigine in controlling seizures, with no intolerable side effects. Researchers also determined that ethosuximide was associated with significantly fewer negative effects on attention.

The national study group recommended long-term follow-up for study participants, and recently received a five-year extension from the NIH.

"Collaborative studies like this lay the groundwork for many critically important studies to follow that will define the proper care of children with seizures," Dr. Roberts said.

Childhood absence epilepsy is the most common form of pediatric epilepsy syndrome, accounting for up to 17 percent of all childhood epilepsy cases. It is characterized by frequent, nonconvulsive seizures that last up to 30 seconds and cause the child to stop what he or she is doing and stare. Following a seizure, children resume what they were doing without any awareness of what happened.

Left untreated, childhood absence epilepsy can interfere with a child's ability to play and learn. For more information about the disease: www.epilepsyfoundation.org or www.epilepsy.com

SENATOR BATES

Continued from page 1

covered by the OHP would not be impacted by the public option, either.

"What we're saying is, we just want to allow everyone the option to buy into the Medicaid program," Bates said. "That's something that's never been allowed before, but it would give people another choice."

Of course, there would be obstacles in Bates' way. For starters, there's existing opposition to public option plans, as evidenced during the health care debate on the federal level. Bates said many people are also against the idea of expanding a government program or handing the government too much control over something like health care, even though the largest health care plans in the state — Medicare and Medicaid — are run by the government.

Large insurance companies, not wanting the competition, would also likely oppose a public option.

As for physicians, Bates said some would probably welcome a public option, while others might find it objectionable.

"The Oregon Health Plan pays pretty well depending on what field you're in," he said. "But various specialists might not care for it so much. Some hospitals might feel the same way about it."

He encouraged physicians to at least consider the idea.

"At least think about this as a way to help the patients you see every day who don't have insurance," he said. "Don't dismiss it outright."

A public option in Oregon would also not impact the health care reform work that Bates and his colleagues in the Legislature tended to last session. One new law created the Oregon Health Authority, an agency that oversees existing state programs and is working to implement cost control measures. The other expanded OHP to cover an additional 80,000 uninsured Oregon children and 35,000 low-income adults via a 1 percent assessment on health insurers and a floating assessment on hospitals.

"The public option fits perfectly with what we've been doing for the past six years," Bates said.

He stressed, too, that any effort at a public option would be entirely nonpartisan so as to prevent it from "dying before it started" the way it did on the federal level. No one will be surprised at the last minute, either, Bates said, referencing the massive bill put before members of Congress just hours before a vote.

"We don't want to do anything like that," he said.

Bates was scheduled to meet with Sen. Wyden and State Rep Mitch Greenlick, D-Portland, in early May to further discuss the idea and find out what might actually be reasonable and realistic.

And come the 2011 legislative session, Bates will be focused almost entirely on the public option issue.

"Our goal," he said, "is to get universal coverage for all Oregonians."

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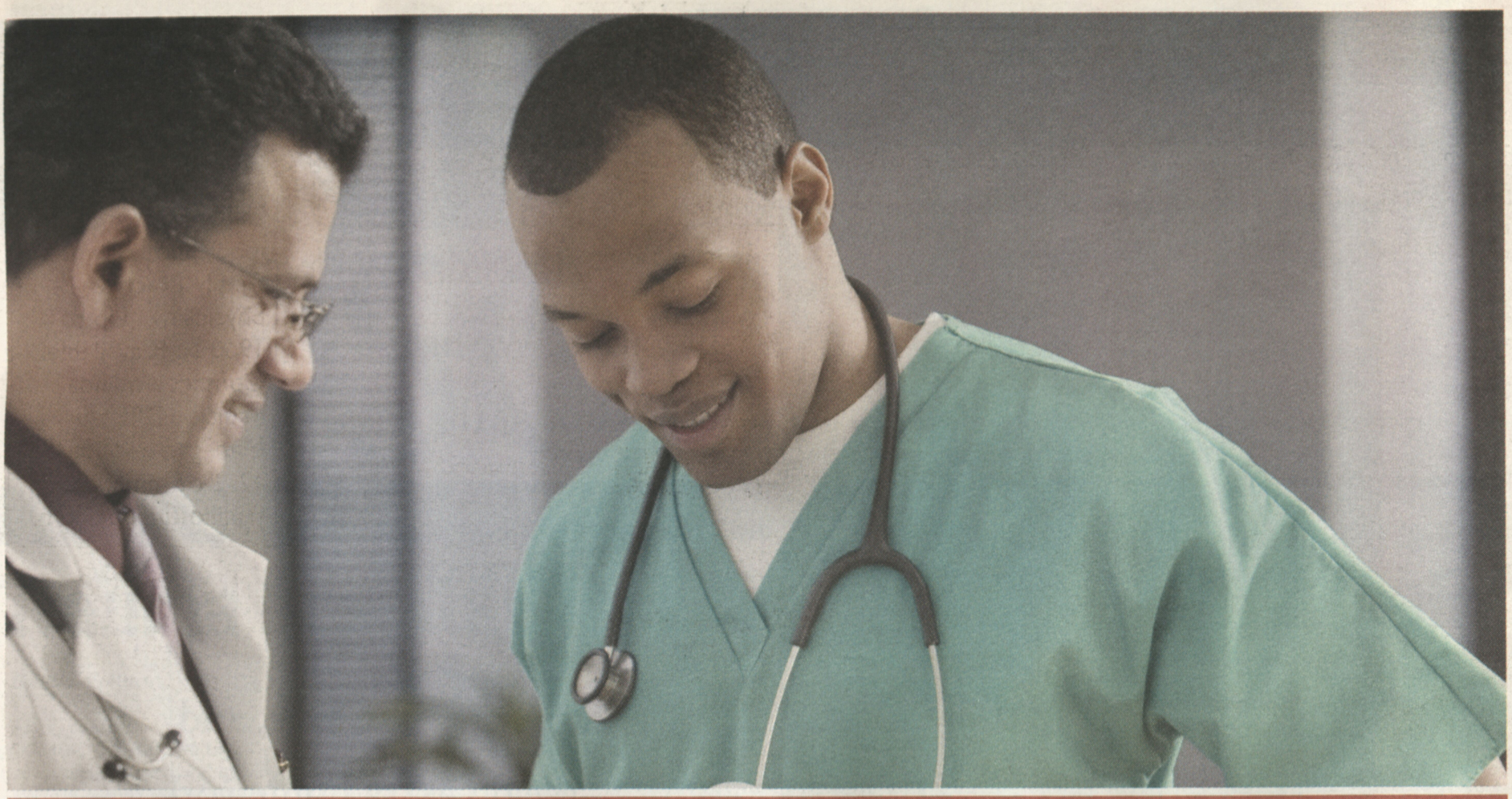

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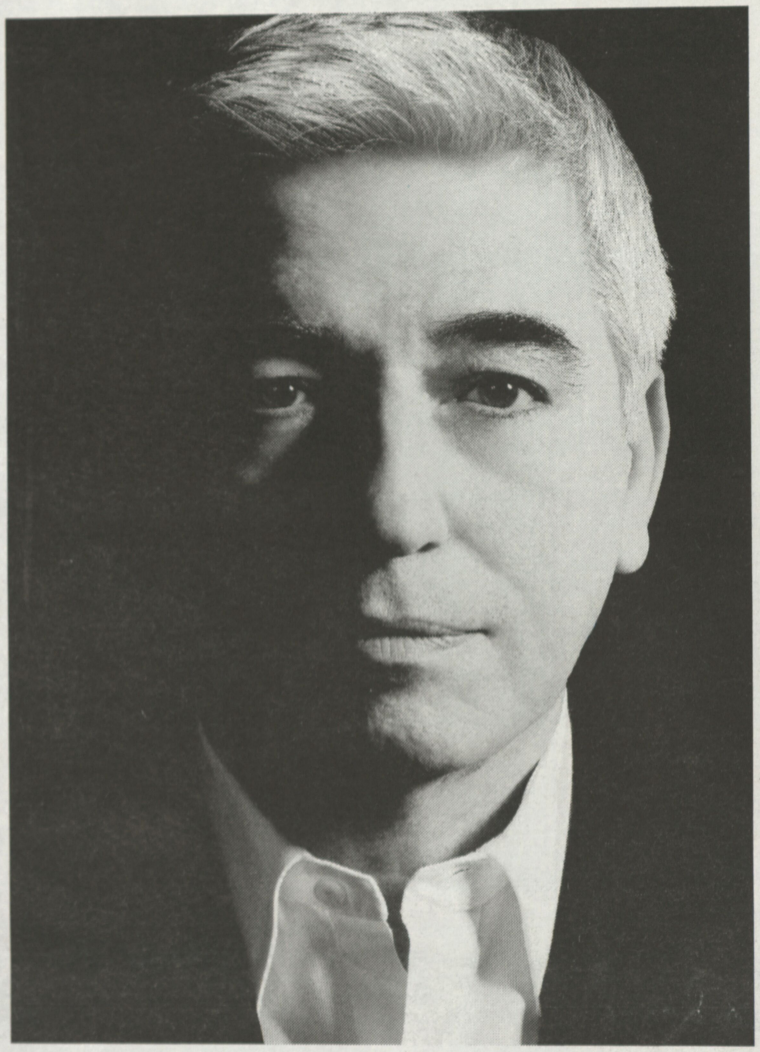

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